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U.S. Regulatory Commission Document Control Desk Washington, DC 20555

LER 354/04-007-00 HOPE CREEK GENERATING STATION – UNIT 1 FACILITY OPERATING LICENSE NO. NPF-57 DOCKET NO. 50-354

This Licensee Event Report entitled, Technical Specification – Inoperable Radiation Effluent Monitor On North Plant Vent, submitted pursuant to the requirements of 10CFR50.73(a)(2)(i)(B).

Sincerely,

James Hutton

Plant Manager - Hope Creek

Attachment

**RFY** 

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NRC FORM 366 U.S. NUCLEAR REGULATORY COMMISSIO							ON APPROVED BY OMB: NO. 3150-0104 EXPIRES: 06/30/2007									
(See reverse for required number of digits/characters for each block)								Estimated burden per response to comply with this mandatory collection request: 50 hours. Reported lessons learned are incorporated into the licensing process and fed back to industry. Send comments regarding burden estimate to the Records and FOIA/Privacy Service Branch (T-5 F52), U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001, or by internet e-mail to infocollects@nrc.gov, and to the Desk Officer, Office of Information and Regulatory Affairs, NEOB-10202, (3150-0104), Office of Management and Budget, Washington, DC 20503. If a means used to impose an information collection does not display a currently valid OMB control number, the NRC may not conduct or sponsor, and a person is not required to respond to, the								
1. FACILITY NAME							2. DOCKET NUMBER 3. PAGE									
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4. TITLE																
Technical Specification Noncompliance – Radiation Effluent Monitor On North Plant Vent																
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FACILITY NAME  R. Yewdall, Licensing Engineer  856-339-2469								rea Code)								
13. COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT																
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14. SUPPLEMENTAL REPORT EXPECTED								15. EXPECTED MO		монтн	DAY	YEAR				
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ABSTRACT (Limit to 1400 spaces, i.e., approximately 15 single-spaced typewritten lines)

On August 24, 2004 at 1310 while completing a weekly sample collection activity on the North Plant Vent (NPV) radiation monitor skid, a test connection valve was found open. With the valve in the open position, air being monitored by the NPV radiation monitoring system was drawn locally from the room diluting process flow from the NPV. This configuration issue appears to have occurred sometime on August 19, 2004 following corrective maintenance on the NPV monitor skid. With the effluent monitoring system in this condition, required sampling for radioiodine, radioactive particulates and noble gases would have been affected. Inability of proper sampling and monitoring of the NPV radiation monitor is a non-compliance with Technical Specification (TS) 3.3.7.5, Accident Monitoring, and Offsite Dose Calculation Manual (ODCM) 3.3.7.11. During the period from August 19 to August 24, 2004 neither required sampling nor the preplanned alternate monitoring was implemented. The preplanned alternate monitoring was not implemented because the position of the test connection valve which caused this condition was not apparent.

There were no safety consequences associated with this event because the system is not safety related or required for shutdown of the unit. Corrective actions included realignment of the valves to the correct position and capping the test connection and performing a vacuum test to ensure sampling system integrity.

This event is being reported in accordance with 10CFR50.73 (a) (2) (i) (B), Any operation or condition which was prohibited by the plant's Technical Specifications.

# NRC FORM 366A

(1-2001)

#### U.S. NUCLEAR REGULATORY COMMISSION

# LICENSEE EVENT REPORT (LER)

FACILITY NAME (1)	DOCKET (2)	LER NUMBER (6)			PAGE (3)
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Hope Creek Generating Station		2004	- 007 -	00	

TEXT (If more space is required, use additional copies of NRC Form 366A) (17)

### PLANT AND SYSTEM IDENTIFICATION

General Electric – Boiling Water Reactor (BWR/4) Radiation Monitoring System {RM/--}\*

\* Energy Industry Identification System [EIIS] codes and component function identifier codes appear as {SS/CCC}

### **IDENTIFICATION OF OCCURRENCE**

Event Date: August 19, 2004 Discovery Date: August 24, 2004

#### CONDITIONS PRIOR TO OCCURRENCE

Hope Creek was in Operating Condition 1 (Power Operation), at the time of discovery. No other required structures. systems or components were inoperable at the start of this event that contributed to the event.

### **DESCRIPTION OF OCCURRENCE**

On Tuesday August 24, 2004 at 1310 hours, while completing a weekly sample evolution on the North Plant Vent (NPV) radiation monitor (RM) skid, it was observed that the skid was not able to pass the system integrity vacuum test. Upon investigation it was discovered that valve 1SPV-081, a sample test connection valve, had been inadvertently left open apparently during corrective maintenance that had been performed on August 19, 2004. With this valve open, the process flow path for the skid was effectively diluted as room air was drawn into the normal process flow from the North Plant Ventilation ductwork. The physical location of the valve left open on the skid was such that the high, mid and low noble gas monitors, iodine and particulate sampler would have been affected by this oversight. Technical Specification (TS) Section 3.3.7.5 for Accident Monitoring as well as Offsite Dose Calculation Manual (ODCM) Section 3.3.7.11 would have been applicable for the condition described. The preplanned alternate method of monitoring of periodic grab sampling and analysis of the effluent release stream was not established. This is contrary to the requirements of TS 3.3.7.5 and the ODCM.

Upon discovery the condition was rectified by closing the sample test connection valve and installing the end cap. The North Plant Vent radiation monitor system was then declared operable. Though alternate sampling capability was available, it was not recognized that it was required.

During the condition review it was determined that the valve was apparently left open while performing maintenance and calibration using Hope Creek NPV radiation monitor maintenance procedure HC.IC-CC.SP-0015 (Q), Process Radiation Monitoring. The work was managed under Workorder 50061401. The maintenance procedure requires that the test valve be fully closed following maintenance or sampling. Because the sample valve was found open this is a procedure noncompliance problem and not a system component failure.

This event is being reported in accordance with 10CFR50.73 (a) (2) (i) (B), Any event or condition which was prohibited by the plant's Technical Specifications. Also requirements of the Hope Creek ODCM section 3.3.7.11 were not complied with.

NRC FORM 366A (1-2001) U.S. NUCLEAR REGULATORY COMMISSION

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		2004	- 007 -	00	

### **CAUSE OF OCCURRENCE**

The cause of this occurrence was due to lack of procedure compliance. Specifically, procedure requirements to isolate the test connection by closing the valve and capping the test connection were not performed. In addition, verification of this activity was not performed.

## **PREVIOUS OCCURRENCES**

A review of LERs for the two prior years at Hope Creek and Salem was performed to determine if similar events had occurred. There were 3 LERs reporting inoperable conditions involving the NPV radiation monitoring system but none were similar to that which caused this event. LER 354/03-009 which reported an inoperable condition of the high range monitoring capability of the NPV radiation monitoring condition was related to a nonconforming design condition. While that event did not involve procedure noncompliance it may have been prevented had a full system retest been performed following maintenance on the system.

### SAFETY CONSEQUENCES AND IMPLICATIONS

There were no safety consequences associated with this event since it has been determined that during the period of inoperability there were no unplanned or uncontrolled releases from the NPV. During the period of inoperability, inline radiation detectors that monitor potential sources of airborne radioactivity exhausted to the NPV did not detect elevated levels. Had an elevated radiological effluent release occurred from the NPV, the vent sample would have been diluted, thus reducing the assessment capability. However, potential sources of airborne radioactivity that exit by way of the NPV are equipped with inline radiation detection duct monitors. Potential design basis accident sources are monitored by the reactor building ventilation monitoring system and the Filtration, Recirculation, Ventilation System (FRVS) which were not affected by this incident.

A review of this event determined that a Safety System Functional Failure (SSFF) as defined in Nuclear Energy Institute (NEI) 99-02 has not occurred.

#### **CORRECTIVE ACTION**

Corrective actions included:

- Immediate closure of the sample test connection;
- A vacuum test on the sampling system skid was performed to ensure system integrity;
- Human performance issues being addressed in accordance with policies.

### **COMMITMENTS**

This LER contains no Commitments.